RESOLVING CHRONIC CARE NEEDS UNDER AN ACUTE CARE MODEL: IMPLICATIONS IN DISCHARGE PLANNING FOR LONG TERM CARE

Evelyn P. Mahairas, PhD, BCD, Program Director,
ITTG (Interdisciplinary Team Training in Geriatrics),
VA Medical Center, Coatesville, PA
Clinical Assistant Professor, Department of Psychiatry and
Human Behavior, Jefferson Medical College, Thomas Jefferson
University, Philadelphia, PA

Introduction: Chronic Care Needs

The concept, well being of the chronically ill, or of those patients who enter the category of long term care service needs, is one that evokes many images for those who are familiar with this particular at-risk population.

Historically, such concerns can be traced back to the benchmark efforts of Dorothea Dix. Her contributions to the mental health movement in the first half of the 19th century fall into two major accomplishments: 1) advancing social research methodology to document the plight of the indigent mentally ill; 2) behind-the-scenes campaigning of state legislatures for the provision of special services through the establishment of state institutions, referred to then as asylums. These efforts gave public recognition to the need for sustained care for those unable to provide adequately for themselves due to debilitating or chronic illness (Mahairas, 1979).

There are many other well known leaders in the early years of the health care movement who are also worthy of note; contributing to the slowly emerging delivery system of health care services. These underpinnings are embedded in the historic roots associated with the emerging field of social work. For the purpose of this discussion, however, it suffices to acknowledge a continuing public concern over the problems of providing adequate care for the chronically ill (Bachrach, 1988; Talbott, 1980).

In this paper, an at-risk long term care patient population is identified through the application of an exploratory research project conducted at an anonymous VA (Veterans Administration) medical center somewhere in the northeast section of this country. The actual project will be discussed in detail later in this discussion. First, however, it is important to observe that the needs of chronically ill patients today somewhat parallel some of the concerns noted above when addressing unmet needs or lack of services in long term care. Certainly, the extremes documented by Dix of neglected or abuse patients chained in prison cells may not be found in today's more enlightened age. Still, there are clearly serious dilemmas today for health care professionals who are involved in the discharge planning process for the chronically ill and are seeking to develop alternative resources in the community (Mechanic, 1986).

Indeed there is a certain irony within the current crisis in health care delivery system which is, in part, informed by the deinstitutionalization movement in promoting the provision of services for the mentally ill in the least restricted environment. Yet, despite these well meaning intentions, the chronically ill who are in the need of long term care are often without access to critical services in the community needed to assure comprehensive levels of care.

Instead, such patients must often be hospitalized as acute care admissions in order to receive needed attention; becoming, in fact, at risk for becoming institutionalized due to the lack of alternative services in less restrictive levels of care.

The concept of chronic illness takes on new meaning in light of the growing problems associated with long term care needs. A survey of the literature by Blazyk and Canavan (1985) follows this stream of thought by further identifying at-risk populations caught in similar dilemmas.

These concerns which were identified for the study are now intensified by a recent funding mechanism in hospital reimbursements related to the DRG's (Disease Related Groups); accelerating the discharge planning process in answer to budgetary pressures to reduce length of hospital stays (Friedman, 1984). Implications for the field of gerontology/geriatrics are of a similar nature. Problems of health care needs for the older adult are frequently multiple in nature; requiring comprehensive health care planning as the main emphasis for providers in the field of aging. The concerns of clinicians who must deal with such issues is the focus of the research project under examination for this paper.

The Case Study: Bi-level Model of Organizational Analysis

The research under review is entitled, Case Study of a VA Medical Center Changing from Chronic to Acute Care: Professional Reactions to Discharge Planning. Its primary focus is an empirical study of professional staff responses to an in-depth interview on discharge planning. At the time, this topic appeared to be one that would likely be approved by the facility in question since it would be a non-threatening topic. The investigator's interest in this topic was consistent with concerns about the needs for the delivery of health care services along a continuum of care. Since the research was conducted prior to the onset of the DRG's, many of the findings can be interpreted as having intensified since the time the actual survey was done: between August and December, 1982 (Mahairas, 1986/1987).

Because of the nature of the empirical study in identifying critical issues in discharge planning for a VA (Veterans Administration) medical center, it became essential to clarify staff responses. It is only in the context of understanding the VA system and its legacy of roots and entitlement that the study can best present its findings. For the purposes of this paper, some preliminary discussion is needed to establish the relationship of the empirical study in the context of the medical center within the VA system at large.

A systems approach: Interactive forces in the environment

To fully appreciate the scope of the VA system, it must be established that this system represents the largest health care system in the free world. It is also known for its accomplishments in bio-medical research. What is seldom known is the extent of its societal role in education; contributing to about 50% of all health care disciplines' professional training at one point in their educational experiences. This is even more so for many physicians and medical specialties. In its vastness, assumptions are made frequently about this system as a bureaucracy; thought to be fixed and unyielding in its behavior as an organization.

The study's intent was to demonstrate that change, even in such a vast organization, is inevitable due to interactive forces in the environment. It was observed that the medical center under examination was experiencing a transition from a custodial care institution to an acute treatment facility. From a systems perspective (Gray, Duhl, & Rizzo, 1969), it was apparent that the Chronic/Acute shift was being caused by external forces interacting with the medical center in its environment. The research project sought to document the changes taking place due to outside forces while focusing primarily upon staff reactions to such change.

Thus, the major emphasis of the study is an examination of the internal dynamics occurring during the shift from chronic to acute care. Consequently, a bi-level model of organizational analysis was designed in order to examine both the external and internal dynamics occurring during the Chronic/Acute care shift.

Although this discussion will not be able to provide detailed findings regarding the externalities interacting in the medical center's environment, a brief review will be helpful. The four forces affecting the medical center's ability to function as a traditional custodial care institution were identified: a) Deinstitutionalization, causing patients to be placed in the least restrictive setting, preferably into the community (Goldman, Adams, & Tause, 1983); b) Medical School Affiliation, requiring active teaching cases (Iglehart, 1985, December); c) the burgeoning Aging Veteran Population, becoming eligible for health care at age 65; d) Increased Benefits, providing free VA services for aging veterans regardless of income level. Since the watershed year for the World War II cohort was due by 1985, it was anticipated that there would be excessive demands upon the system beyond its present capacity to function (National Academy of Sciences, 1977). This last feature, increased benefits, has since been modified to an adjusted income level for eligibility. Before discussing the empirical study of internal dynamics of the medical center's staff experiencing the Chronic/Acute shift, a brief review of the context in which the VA itself functions will follow.

Ethos of the VA: Roots and entitlements

A longitudinal study of veteran programming reveals the slow evolution of entitlements gradually established throughout the history of this country's development. By tracing the legislative history of veteran benefits, three separate types of programming can be identified; a) Compensation; b) Shelter; c) Health Care. Each identifies specific needs that are publicly sanctioned and achieved through congressional enactments. Also, each reveals an extensive struggle by veteran groups or their dependents to obtain public recognition of these needs. Finally, each advancement tends to represent a generational cohort from wartime or post-war recovery periods which support provisions for veterans and their dependents in order to ease adjustments into the community following military service.

A lengthy discussion of this legislative analysis is beyond the scope of this paper. Yet, there are some landmark legislative events that will be valuable for gaining insights into the legacy of veteran programming represented by the historic roots leading to VA's establishment and its multiple roles within U.S. history. Essentially, the push and pull of veteran benefits fluctuate in accord with public pressures and identified needs to compensate the modern volunteer or citizen army in recognition for service rendered to one's country.

For example, origins to veteran pensions for disabled veterans and their families are found in colonial times and formally enacted by the Continental Congress during the Revolutionary period (1780). A most notable enactment to exemplify this progression in veteran programming can be seen in hospital legislation which established a network of maritime hospitals in the post Revolutionary War era (Seaman's Act, 1789). Hence, two parts of traditional veteran entitlement, compensation-benefits and health care, were already established two centuries ago.

The third part of entitlements was introduced following the War of 1812 when the concept of a "Home" was brought to public attention and finally established by the end of the Civil War by a system of national homes for needy and disabled veterans (National military and naval asylum Act, 1865).

Modern technologies in the 20th century led to the concept of rehabilitation and the centralizing of several veteran programs into a single agency, the Veteran's Bureau, in the post World War I era (1921/1922). This was further organized with the foundation of the VA (1930) and the unification of a national hospital and homes system to further promote veteran readjustment into the community. Two further benchmark legislation are seen in the World War Ii era: a) Passage of the well known "GI" bill (Servicemen's Readjustment Act, 1944); and b) Establishment of the Department of Medicine and Surgery, leading to the development of medical school affiliations with strong emphasis on health care services for veterans (1946).

More recent efforts to limit veteran benefits reflect, in part, changes in public attitudes and perceptions regarding veteran groups' status and entitlement. Even more important, competing interests, shifts in priority setting of public policies, and shrinking resources of creating a press to reduce public expenditures in this direction. The newest organizational change from independent agency to receiving cabinet post status as the Department of Veteran Affairs will be of interest to many in both public and private sectors but is outside the realm of this discussion. Regardless of future directions, it is apparent that the myth of a bureaucracy being rigid and fixed can now be placed in a more realistic framework of responsiveness to external forces interacting in the environment. The remainder of the paper will report on the empirical study (Department of Veteran Affairs [DVA], 1989).

Internal Dynamics: The Empirical Study

This segment of the paper will identify three phases in the research methodology utilized while examining the internal dynamics of the bi-level organizational analysis: a) participant observation; b) in-depth interviewing; c) data analysis. The initial phase of research began with a one year participation observation phase. As referred to earlier, it became evident that there would be an acceleration in discharge planning stemming from the confluence of the four externalities discussed above. Social Work staff traditionally function in the role of Discharge Planning Coordinator at the Medical Center. They were observed expressing concerns over problems in the discharge planning process. Certain key questions began to formulate around this activity. Resistances to discharge planning were being reported informally. References to a "Revolving Door" phenomenon reflected frequent comings and goings of discharged patients (Harris, Linn & Hunter, 1980). Staff appeared reluctant to develop placement plans for veterans who were chronic, long-term patients facing removal from the medical center perceived as "home" and staff as "family."

An in-depth interview schedule was created to identify staff reactions to the Chronic/Acute shift; thus capturing internal dynamics of staff receptivity to the medical center's transformation into an acute treatment facility (Appendix 1). The format was designed to elicit information in a non-threatening manner: 15 short-answer and 10 open-ended questions regarding issues on discharge planning criteria, decision-making concerns for placements, and risk factors contributing to returns following discharge.

Research design and methodology

The research design was intended to compare a group of Social Work staff with a group of Other Professions in responses to the interview schedule. Actual interviewing took place between August and December, 1982. A total of 31 Social Work staff were participants in the study. The Other Professions group consisted of 46 staff members: 10 from Medicine; 10 from Psychiatry; 15 from Nursing, stratified to reflect different levels of training and professional preparation; and 11 from Psychology.

The actual strategies of engaging staff on a voluntary basis to participate in such a project

cannot be discussed in detail. It is interesting to note, however, that an inducement of lunch, unobtrusive interviewing techniques, and a handwritten verbatim recording procedure generated a sufficient trust level to assure a willingness to participate. Subjects were generally highly supportive of the experience. Many expressed appreciation for having an opportunity to discuss their own observations and clinical impressions within the framework of the in-depth survey session. Since the process incorporated opportunity for closure, the subject was able to feel a sense of resolution in concluding the experience by making recommendations for future planning.

Data Analysis

This section of the paper will briefly delineate the steps of data analysis that transposed the interview results representing qualitative methodology into quantifiable data findings. A Data Analysis Flow Chart is provided in order to describe the various steps entailed in operationalizing the data analysis (Appendix 2). With the use of content analysis, 10 constructs were created to help organize the findings: 1) Staff Profiles; 2) Discharge Factors; 3) Placement Factors; 4) Decision-Making Factors; 5) Interfering Factors; 6) Return Factors; 7) Deinstitutionalization; 8) Role of the VA Factors; 9) VA Organization: Problem Factors; 10) Helping Strategies: Organizational Adaptations. A total of 246 categories were coded.

Once the data were coded they were transformed into a computerized format in order to perform quantitative analysis and conduct statistical analysis. Frequencies were compiled and responses compared across the five professional groups. Responses between the two main groups were compared, that is, comparing Social Work (S.W.) with Other Professions (O.P.). Significant findings resulting from Chi Square correlations and Contingency Coefficient calculations were compiled. Those findings that formed an Opposite Directed response between the two groups were scrutinized. These signified that one group's response on a specific item was considered to be important while the other group's response indicated the item to be unimportant. Ratio analysis was frequently calculated in order to discriminate the degree of difference between the two groups' responses pertaining to those items being examined. A final step in the data analysis and report of the findings was to utilize qualitative methodology in providing direct quotes to more effectively illustrate the results being discussed.

Findings: Patient Care and Organizational Concerns

Due to the extensiveness of the data, it is necessary to separate findings into two broad areas: a) Patient Care Indicators; b) Organizational Dilemmas. Furthermore, a large number of items fall into a type of consensus response category designated as a Universal Response, but will not be included in this discussion due to the limitations of this paper. A few representative tables will be included in order to illustrate key significant findings within this part of the discussion.

Patient care indicators

This section reveals a pattern of perceptions in staff responses that clearly indicates a significant difference in professional orientation and perspective on how each group relates to the questions being posed. Those professions that have a bio-medical orientation show more interest in responding to patient management issues and in-patient treatment concerns. The Social Work group relies on a systems approach and places greater emphasis on team orientation and family involvement as seen by Tables 1 and 2 shown here.

Table 1
Placement Factors

PD 040*

	VA In-Patient Support: Team Orientation		
Professional Group	Important	Not Important	Total
Social Work	22	6	31
Other Professions	14	32	46
Total	36	41	77

Chi Square Result	Degrees of Freedom	Probability	Contingency Coefficient
$X^2 = 10.64799$	df = 1	p = <.05	C = .35

*Opposite-Directed Variable

Table 2
Placement Factors

PD 057*

	Non-VA Social Support: Family Involvement		
Professional Group	Important	Not Important	Total
Social Work	20	11	31
Other Professions	11	35	46
Total	31	46	77

Chi Square Result	Degrees of Freedom	Probability	Contingency Coefficient
$X^2 = 11.06223$	df = 1	p = <.05	C = .35

*Opposite-Directed Variable

Furthermore, psychosocial and economic factors are relied upon to a larger extent by this group of discharge planners compared to Other Professions, except for Psychology which also takes some of these factors into account to an extent. In short, a systems approach appears congruent with the Social Work group which places more emphasis on self determination for the veteran patient, greater reliance on out patient services, and supports more independent functioning with reliance on community living arrangements.

Organizational dilemmas

This section will examine responses regarding the medical center's Chronic/Acute care shift. The tables below indicate that the Social Work group is more receptive to this transformation; based on greater consonance with its own systems orientation. Thus, Social Work considers acute care focus under deinstitutionalization to be more compatible with its role in discharge planning as seen in Table 3 below.

Table 3
Deinstitutionalization

DID 180*

	Favorable Factors: VA In-Patient: Accelerates Treatment		
Professional Group	**Important**	**Not Important**	**Total**
Social Work	22	9	31
Other Professions	14	32	46
Total	36	41	77

Chi Square Result	Degrees of Freedom	Probability	Contingency Coefficient
$X^2 = 10.64799$	df = 1	p = <.05	C = .35

*Opposite-Directed Variable

This view suggests that deinstitutionalization is more compatible with Social Work, that the discharge process is supported by a greater emphasis on treatment planning, and that established treatment goals can facilitate the decision-making process. In contrast, as seen in Table 4 below, Other Professions consider deinstitutionalization to be ineffective within a bio-medical orientation which considers chronic care needs from an in-patient, treatment perspective. Objections also state that there is no real difference, at times, when comparing a community setting with an in-patient setting.

Table 4
Deinstitutionalization

DID 183*

	Unfavorable Factors: Not Effective		
Professional Group	**Important**	**Not Important**	**Total**
Social Work	7	24	31
Other Professions	27	19	46
Total	34	43	77

Chi Square Result	Degrees of Freedom	Probability	Contingency Coefficient
$X^2 = 8.385899$	df = 1	p = <.05	C = .31

*Opposite-Directed Variable

Two distinct orientations appear here. The S.W. group bases its choices on the underlying assumptions that leaving the medical center is a preferred goal; placing its priority in community living as in the best interest of the patient. The O.P. group, instead, judges departure from the medical center as detrimental to the therapeutic needs of the patient; considering out-placement as potential for substitute institutionalization in a community setting. The Social Work group's support of the Chronic/Acute care shift is further reinforced in Tables 5 and 6 below, which look at the VA Role in an acute treatment

approach of restricting the degree of custodial care and relying on an acute/triage level of intervention to support that role. Other Professions favor some custodial care to address the problems of some veteran patients with long term care needs.

Table 5
Role of VA Factors

RVA 201*

	VA Role Acute versus Other		
Professional Group	**Acute**	**Other**	**Total**
Social Work	19	7	26
Other Professions	14	22	36
Total	33	29	62

Chi Square Result	**Degrees of Freedom**	**Probability**	**Contingency Coefficient**
$X^2 = 5.780954$	df = 1	p = <.05	C = .29

*Opposite-Directed Variable

Table 6
Role of VA Factors

RVA 206*

	Level of Intervention VA Role: Acute/Triage versus Other		
Professional Group	**Acute/Triage**	**Other**	**Total**
Social Work	21	9	30
Other Professions	9	37	46
Total	30	46	76

Chi Square Result	**Degrees of Freedom**	**Probability**	**Contingency Coefficient**
$X^2 = 17.27854$	df = 1	p = <.05	C = .43

*Opposite-Directed Variable

Social Work also supports the Chronic/Acute care shift by emphasizing increased out-patient services, family supports, and comprehensive programming to meet the needs for alternatives in the community. These are seen in Tables 7 and 8 below.

Table 7
Role of VA Factors

RVA 208*

Professional Group	VA Role: Out Patient Services: Family Support Important	Not Important	Total
Social Work	22	9	31
Other Professions	14	32	46
Total	36	41	77

Chi Square Result	Degrees of Freedom	Probability	Contingency Coefficient
$X^2 = 10.64799$	df = 1	p = <.05	C = .35

*Opposite-Directed Variable

Table 8
Helping Strategies

HS 246*

Professional Group	Future System Change: Extended Care-Family Supports Important	Not Important	Total
Social Work	27	4	31
Other Professions	9	37	46
Total	36	41	77

Chi Square Result	Degrees of Freedom	Probability	Contingency Coefficient
$X^2 = 31.26789$	df = 1	p = <.05	C = .54

*Opposite-Directed Variable

Implications for Long Term Care

It is clear that the two groups represent very different views in their responses to specific issues regarding the Chronic/Acute care shift. It is also evident that, based on professional orientations, the responses represent valid justifications in direct relation to each group's own disciplinary perspective: bio-medical or psychosocial. This does not bring into the discussion the many elements of accord identified in the empirical study. These are evident under the many Universal Responses which could not be incorporated within this discussion.

If the Social Work group's systems approach is relied upon, and comprehensive services are available in the community, then many chronically ill, or elderly patients in long term care, will be able to receive alternative levels of care. However, it is clear that the Other Professions group is expressing serious concerns about that very aspect in long term care: unmet needs in the community for the chronically ill and elderly in long term care. In point of fact, each group shows professional concerns which are congruent within their own orientations and represent valid points when placed along a spectrum of long term care issues.

One effective way of helping to resolve such disparities is to maintain a focus on the issues of discharge planning based on the needs of the chronically ill and elderly in long term care within a continuum of care perspective. Each patient can thus be offered options in alternative levels of care along the continuum of care. This approach recognizes that out-patient care and family supports must be provided on a sufficiently comprehensive level of care in order to satisfactorily address the concerns of those unmet needs. If this perspective is used, then there will be greater likelihood that long term care needs will be resolved in a constructive manner and be more fully integrated within the discharge planning process. This is more likely to occur through an interdisciplinary team approach (Ducanis & Golin, 1979).

In conclusion, to effectively reach this level of team interaction, an interdisciplinary health model can be highly valuable when applied to the decision-making process for discharge planning (Appendix 3). This gives recognition to the importance of each discipline's contribution to the overall care of the patient (Mahairas, 1989). Ultimately, the needs of the chronically ill and elderly patients in long term care are more likely to be met when all these perspectives are represented in the discharge planning process and guided by the principles incorporated within the interdisciplinary health model.

Appendix #1
Interview Schedule

1. Identifying Code Number (code to be developed for confidentiality)
2. Professional Degree _____ Year obtained _____
3. Age _____ Male _____ Female _____ Race _____
4. Employment Status: VA _____ Non-VA _____
5. Length of VA Employment: _____ years CVAMC _____ years
6. Relationship/Affiliation Status:
7. Position role in treatment team:
8. Type of Ward: Chronic _____ Acute _____
   Specialized: Program _____ Service _____
9. Degree of participation in direct service with patients: _____ % of time
10. Amount of participation in discharge planning:
11. How is it initiated? Which staff members are usually involved?
12. How involved is whole team? Formality ___ Supportive _____ None _____
13. What is the most successful type of discharge?
14. What is the most successful type of placement?
15. What factors are most helpful in decision-making?
16. What factors interfere the most?
17. What are some of the problems leading to returns?
18. Is there a tendency to single out specific staff as responsible for the readmission? Who would generally be accountable?
19. Familiarity with subject of deinstitutionalization?
20. Feelings about it? How does it affect patient care?
21. How does it fit with the mission of the VA? What should the role of the VA be in caring for veteran patients?
22. What would help most? Recommend for future planning?

Appendix #2
Data Analysis Flow Chart

PROFESSIONAL GROUP SURVEY	CONTENT ANALYSIS	QUANTITATIVE ANALYSIS: Computerized Format		QUALITATIVE ANALYSIS:

N = Total # Subjects
n = total # within each discipline
	Major Categories
	N = 10
		Data Input		Handwritten Verbatim Responses

Social Work 31 Psychiatry 10 Medicine 10 Psychology 11 Nursing 15 N = 77	Staff Profiles Discharge Factors Placement Factors Decision-Making Factors Interfering Factors Return Factors Deinstitutionalization Role of VA Factors VA Organization: Problem Factors Helping Strategies: Organizational Adaptations Total Coded Categories: N = 246	Statistical Analysis: Chi Square Correlations Contingency Coefficients Responses Compared Across Five Professional Groups: Frequencies Significant Findings	Responses Compared Between Main Groups: Social Work (S.W.) versus Other Professions (O.P.) Significant Findings Opposite Directed Responses Ratio Analysis: SW greater than OP SW lesser than OP	Coding Symbols Selected Illustrative Quotations Relevant to Findings Discussed in Text
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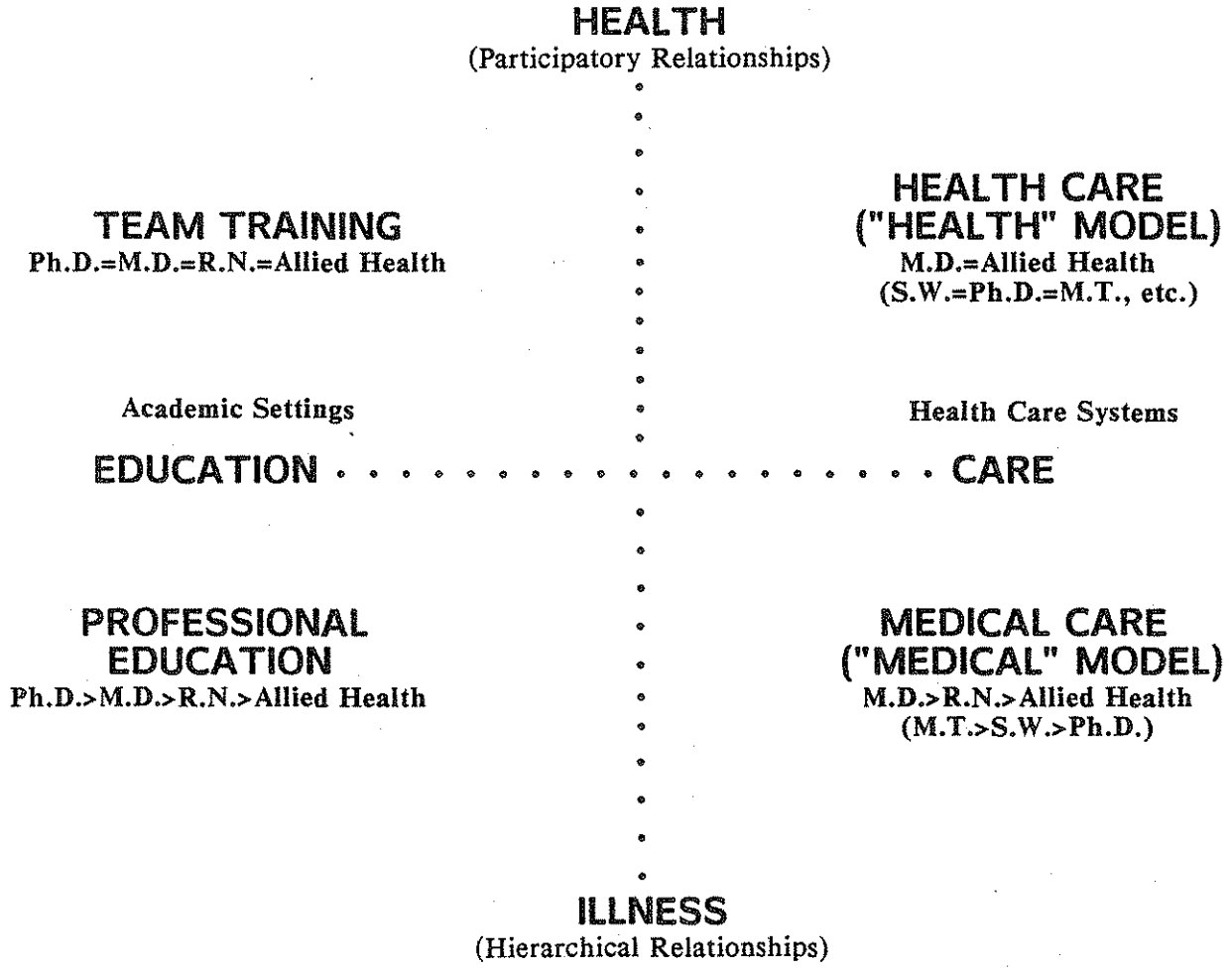
Appendix #3

INTERDISCIPLINARY HEALTH MODEL

POLARITIES AFFECTING ROLE RELATIONSHIPS



Adapted from: Barbara C. Thornton, Edna D. McCoy, and DeWitt C. Baldwin, Jr., "Role Relationship on Interdisciplinary Health Care Teams," in DeWitt C. Baldwin, Jr., Beverly Davies Rowley, Virginia H. Williams (Ed.s), Proceedings of the First Annual Conference on Interdisciplinary Teams in Primary Care (pp. 217-233) (Seattle, Washington: New Health Perspectives, Inc. and School of Medicine/University of Nevada, Reno, 1980), p. 232.

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